2013 WL 8214484 (Ill.App. 4 Dist.) (Appellate Brief)
Appellate Court of Illinois, Fourth District.

In Re the Matter: Mary SLEPICKA, by and through Joann Kaminski, her agent and Attorney-in-fact, Plaintiff-Appellant,

v.

STATE OF ILLINOIS, acting through the Illinois Department of Public Health and Teresa Garate, Ph.D., its Assistant Director, and LaMar Hasbrouck, MD, MPH, its Director, and Holy Family Villa, Defendant-Appellees.

No. 2012-1103.
March 11, 2013.

Appeal from the Circuit Court of the Seventh Judicial Circuit, Sangamon County, Illinois
Circuit No.: 2012-MR-743
The Honorable John Schmidt, Judge Presiding.
Oral Argument Requested

Appellant's Brief

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***1** I. POINTS AND AUTHORITIES

***2**

II. INTRODUCTORY PARAGRAPH

This matter is on appeal from a final judgment of the circuit court affirming a decision of the Illinois Department of Public Health on administrative review. No jury was involved. An issue is presented regarding the pleadings, but not in the usual sense. The initial administrative matter was initiated by the Defendant, Holy Family Villa, by serving a Notice of Involuntary Transfer or Discharge and invoking federal law. (C.631). The agency decided the case under Illinois law. (C.22).

III. STATEMENT OF THE ISSUE

Whether under the federal law invoked by the facility, the Department erred in ordering the involuntary discharge of the Plaintiff from the facility of the Defendant, HOLY FAMILY VILLA, when the Plaintiff was approved for and paid the facility sums far exceeding allowable charges under Medicaid, i.e. whether the Department can lawfully sanction a licensed Medicaid facility to manipulate its bed assignments to deprive a resident of approved Medicaid benefits allowed under Medicaid?

*3 IV. STATEMENT OF JURISDICTION

The Court has jurisdiction under Rules 301 and 303 of the Rules of the Illinois Supreme Court. The trial court entered its final order on administrative review on November 28, 2012. (C.712). Notice of Appeal was filed on December 3, 2012. (C.717).

V. PERTINENT PART OF REGULATION INVOLVED

42 C.F.R. 483.12(a)

(a) Transfer and Discharge

(2) Transfer and discharge requirements. The facility must permit each resident to remain in the facility, and, and not transfer or discharge the resident from the facility unless-

(v) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who become eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable changes under Medicaid;

VI. STATEMENT OF FACTS

Holy Family Villa ("the facility") is a skilled nursing care facility in Palos Park, Illinois. (C.387; C.388). The facility contains 99 beds, of which 65 are Medicaid-certified beds and 33 are "private-pay" beds. (C.420). Ms. Slepicka ("the Plaintiff") was admitted to the facility on *4 March 29, 2011. (C.9). Medicare paid for the Plaintiffs care from March 29, 2011 until April 9, 2011, at which point the Plaintiff was changed to private-pay status. (C.391). Mrs. JoAnn Kaminski, agent and attorney-in-fact for Ms. Slepicka, signed a second contract with the facility on April 10, 2011, a copy of which is in the Appendix. (A.13). The contract gave the facility control over bed placement:

24. Room Assignments and Roommates. **HOLY FAMILY shall assign rooms and roommates as needed.** Resident has the right to reside and receive services in HOLY FAMILY with reasonable accommodation of individual needs and preferences, except when, as determined by HOLY FAMILY, the health or safety of Resident or of other residents would be endangered. Resident, Resident's legal representative, if any, or interested family member has the right to receive notice before Resident's room or roommate is changed. Resident has the right to share a room with his or her spouse when married residents live in the same HOLY FAMILY and both spouses consent to the arrangement. Resident has a right to refuse a change of room within HOLY FAMILY if the purpose of the change is merely for the purpose of obtaining Medicaid funding. (C.220). (Emphasis added.)

The contract also required the Plaintiff and her agents "to take all steps necessary to apply for and obtain public assistance under any program for which Resident may be eligible." (C.208; A. 14). While the April 10, 2012 contract was in effect, the facility offered to apply for Medical Assistance ("Medicaid") on the Plaintiffs behalf. (C.403). During the summer of 2011, Mrs. Kaminski supplied documentation to the facility so they could begin the application process. However, the facility did not apply for Medicaid. (C.404; C.495).

***5** In August of 2011, Mrs. Kaminski met with Jerry Schmitt, a Certified Financial Planner ™, to assist in applying for Veteran's benefits. Mr. Schmitt referred Mrs. Kaminski to Joe Oettel of Lighthouse Financial 8& Consulting Services, LLC to assist in applying for Medicaid benefits. (C.508-C.540).

On September 27, 2011, the Plaintiff met with her attorney, Michael T. Conroy. (C.514). Also present were Mrs. JoAnn Kaminski, Slepicka's agent under Power of Attorney, Mrs. Kaminski's husband, Joe Kaminski, and Joe Oettel. At that meeting, Mr. Oettel, also a Certified Financial Planner ™, explained the Medicaid program and application process to the Plaintiff and her attorney. The Plaintiff's attorney advised the Plaintiff to contract with Mr. Oettel to handle her Medicaid application rather than the facility. On that advice the Plaintiff contracted with Mr. Oettel's firm, Lighthouse Financial & Consulting Services, LLC to be her Approved Representative and apply for Medicaid on her behalf. (C.518-C.519).

During the September 27, 2011 meeting at Mr. Conroy's office, in the presence of the Plaintiff, Mr. Oettel called the facility and spoke with the facility's Fiscal Manager, Audrey Sparks. (C.104). Mr. Oettel informed Ms. Sparks he was applying for Medicaid for the Plaintiff and would request an effective date backdated to June 1, 2011 as allowed by Medicaid policy. (C.519). Mr. Oettel testified he asked Ms. Sparks if the Plaintiff was in a Medicaid-certified bed and that Ms. Sparks told him ***6** she believed the Plaintiff was in a Medicaid-certified bed, but that she would check to make sure and, if the Plaintiff was not in a Medicaid-certified bed, Ms. Sparks would contact Mr. Oettel. (C.518-519). Mr. Oettel testified he never received a call back indicating the Plaintiff was not in a Medicaid-certified bed. (C.519).

The facility acknowledges that Mr. Oettel told it in late September he was filing for Medical Assistance under Medicaid. (C.182). Mr. Oettel applied for Medical Assistance for the Plaintiff with the Department of Human Services ("DHS") on September 30, 2011. (C.520-C.522). On the November 1, 2011 billing statement the facility administrator noted, "she remains in a non-certified bed waiting for a certified bed." (C.623; A. 12).

On January 24, 2012, the facility served the Plaintiff with a Notice of Involuntary Transfer or Discharge and Opportunity for Hearing, alleging nonpayment (C.395) because the Plaintiff had not been paying the full private-pay rate. (C.396; C.631). Ms. Slepicka demanded a hearing under the notice. (C.684). A pre-hearing conference was held at the facility on February 23, 2012 with Illinois Department of Public Health ("DPH") Administrative Law Judge Omayra Giachello, facility administrator Roberta Magurany, facility attorney Amy McCracken, and Mr. Oettel as the Plaintiff's representative. Mr. Oettel provided spreadsheets showing what the Medicaid calculations would be for each month once DHS correctly approved the Plaintiff's Medicaid application. These calculations indicated that Ms. Slepicka had already overpaid the ***7** facility based on the projected Medicaid payments. (C.48; A.29). These calculations later proved accurate and exact to the penny. (Cf. the spread sheets at C.48; A.29 and the final Medicaid decision at C.136)

DHS approved the Plaintiffs application for Medicaid on February 17, 2012. (C.651). The initial decision included several errors for her obligations from June through September of 2011. A timely appeal to the Bureau of Assistance Hearings was filed with DHS on April 3, 2012. (C.379). The Medicaid decision was revised and corrected several times over the following months. (C.522; C.525). On July 6, 2012, DHS revised the decision to the correct amounts and dates and approved the Plaintiffs Medicaid status effective back to June 1, 2011. (C.136). Mr. Oettel forwarded the decision to the ALJ and withdrew the appeal with DHS. (See final decision and withdrawal of appeal attached to the Memorandum to support Application for Stay at C.18 C.308.) Although the Involuntary Discharge hearing was held on May 24, 2012, the ALJ held the record open to receive the final Medicaid decision. (C.381). The decision was sent to her on July 11, 2012 when it was issued. (C.308). Because the record

on review did not contain the final Medicaid decision, the Plaintiff sought and received the approval of the circuit court to supplement the record with a copy of the decision, and the withdrawal of the departmental appeal. (C.732).

On May 24, 2012, the hearing with DPH regarding the involuntary discharge took place at the facility. (C.373). The facility maintained that ***8** because it had assigned the Plaintiff to a private-pay bed, despite her eligibility for and eventual receipt of Medicaid benefits, the Plaintiff had to pay the facility private-pay rates or be discharged. The decision by the Administrative Law Judge approving the involuntary discharge is dated August 30, 2012. (C.22). See Exhibit A attached to Complaint; it was received on September 4, 2012. (C.7; A.5).

Plaintiff filed for administrative review in the Circuit Court on September 14, 2012. (C.1). On September 19, 2012 the Plaintiff applied for stay pending review. (C.18). The trial court entered a stay. (C.731 d/e dated 10/12/2012; C.340).

The matter was briefed for the circuit court and argued by the Plaintiff and the facility. The Department of Public Health appeared but did not file a brief or otherwise defend the decision of the Department. (C.322). After argument, the trial court affirmed the Department's decision without comment or explanation and dissolved the stay. (C.712).

Notice of Appeal was filed on December 3, 2012. (C.717). An application for stay was made to the trial court (C.714) and denied. (See d/e dated 12/5/2012; C.720). A Supporting Record and an application for stay was made to this court on December 12, 2012, but it was denied.

The facility moved to dismiss the appeal for “mootness” but that too was denied. A third party paid sums to the facility under protest to avoid disturbing Ms. Slepicka. (These matters would only appear in the record made at the Appellate Court.)

***9 VII. ARGUMENT**

A. STANDARD OF REVIEW

The appellate court reviews the departmental decision, not the judgment of the circuit court. *Vincent v. Department of Human Services* (2009) 392 Ill.App.3d 88, 331 Ill.Dec.314, 910 N.E.2d 723.

Review of decisions of law is *de novo* since the court gives no deference to decision of law made by the agency. *City of Belvidere v. Illinois State Labor Relations Bd.* (1998) 181 I11.2d 191, 229 Ill.Dec. 522, 692 N.E.2d 295. *Cinkus v. Village of Stockney Municipal Officers Electrical Board* (2008) 228 I11.2d 200, 319 Ill.Dec. 887, 886 N.E.2d 1011.

The agency applied state law when federal law was invoked. Under federal law the Plaintiff has not “failed, after reasonable and appropriate notice, to pay... the facility,” but has actually *overpaid* the facility by $28,246.41. Thus the issue is to be reviewed de novo.

The facility tried to inject a question of fact asserting that “no Medicaid beds were available.” There were beds available. Where a decision is not supported by competent evidence the decision is against the manifest weight of the evidence as a matter of law. *Polk v. Bd. of Trustees of Police Pension Fund of Park Ridge* (1993) 253 Ill.App.3d 525, 197 Ill.Dec. 14, cert. den. 631 N.E.2d 718.

***10** If the issue is characterized as presenting a question of fact, i.e., whether there was a Medicaid certified bed available to assign Mrs. Slepicka to, the standard on review would be whether the decision was against the manifest weight of the evidence. *Carver v. Bond/Fayette/Effingham Regional Board of School Trustees* (1992), 146 I11.2d 347, 167 Ill.Dec. 1, 586 N.E.2d 1273; and, it is the decision of the agency and not the hearing officer which is entitled to deference, if any. *Starkey v. Civil Service Com‘n* (1983), 97 I11.2d 91, 73 Ill.Dec. 405, 454 N.E.2d 265. Here, the agency merely rubber-stamped erroneous the erroneous decision of the hearing officer.

B. THERE WAS NO BASIS IN LAW FOR THE FACILITY TO SEEK THE INVOLUNTARY DISCHARGE OF THE PLAINITFF, NOR ANY BASIS IN LAW FOR THE AGENCY TO ORDER THE INVOLUNTARY DISCHARGE OF THE PLAINTIFF.

1. The Department Has Not Made Any Effort to Justify the Decision.

The Department chose not to file any brief or argument to support its own administrative law judge at the circuit court level. This is understandable because the ALJ grossly departed from her duties and chose to ignore the applicable law. The decision is indefensible. The facility filed its notice of involuntary discharge under federal law. The ALJ, apparently to find for the facility, applied state law and has not tried to explain why she did so. Whether the result under state law would differ from federal law is not clear because Medicaid rules cannot be more restrictive than federal law. *Poindexter v. Illinois* (2008) 229 III. 2d ***11** 194, 321 III, Dec 688, 890 N.E. 2d 410, cert den. (2008) U.S. 5536. Federal law is clear.

2. Applicable federal law makes it clear there was no failure to pay as alleged - there is a large overpayment and the actions of the facility and the department are indefensible.

The Notice of Involuntary Transfer or Discharge and Opportunity for Hearing served on the Plaintiff was filed on January 24, 2012. (C.631; A.8). The facility filed the case as a federal proceeding (C.631) and under 42 C.F.R. 483.12(a)(2)(v); the notice as served on Ms. Slepicka states: "...you have failed, after reasonable and appropriate notice, to pay for your stay at this facility," referencing 42 CFR 483.12(a)(2)(v). (C.631; a copy of the Notice is reproduced in the Appendix at A.8). The Department acknowledged the case as a "federal proceeding." (See C.685).

The notice truncated subparagraph (v) of 42 CFR 483.12(a)(2) and omitted important and dispositive terms. The notice was therefore inaccurate, incomplete and even deceptive; 42 C.F.R. 483.12(a)(2)(v) *reads in full:*

> ...the resident has failed, after reasonable and appropriate notice, to pay for **(or to have paid under Medicare or Medicaid)** a stay at the facility. **For a resident who becomes eligible for Medicaid after admission to the facility, the facility may charge only allowable charges under Medicaid.** (Emphasis added.)

The decision on review makes no mention of federal law, rather the ALJ states she decided it under Illinois law, to wit: the Nursing Home ***12** Care Act, 210 ILCS 45/1-101 *et seq.* (C.9).[1] The facility acknowledged its notice was issued under 42 C.F.R. 483.12(a)(2)(v). (C.631). The complete text of 42 C.F.R. 483.12(a)(2)(v) makes it crystal clear that the facility and the Department acted unlawfully toward the Plaintiff. The legislature cannot delegate to an agency the legislative power to determine what the law should be; the delegated authority is to execute the law delegated. *Maun v. Department of Professional Regulation* (1998), 299 Ill.App.3d 388, 701 N.E.2d 791. It was for the Department of Public Health to execute the law delegated to it and invoked by the facility, not to arbitrarily chose other rules. *People v. Hall* (2000), 314 Ill.App.3d 688, 732 N.E.2d 742.

The facility invoked federal law and federal law prohibits the facility's effort, whether by high-handed techniques such as involuntary discharge *or otherwise*, from every effort to collect from the Plaintiff sums not expressly allowed by her Medicaid eligibility decision. The undisputed evidence, based on the Plaintiff's actual Medicaid eligibility as finally decided[2], was that Ms. Slepicka had over paid the facility by **$28,246.41.** There was no "failure to pay" sums when due for a stay. The facility's bill claiming an outstanding balance is invalid and calculated on a fiction confected by it. It was because the facility "considered her private pay." (C.412).

***13** Significantly, the regulation reads prospectively, "For a resident who **becomes** eligible for Medicaid after admission to the facility, the facility may charge only allowable charges under Medicaid." The rule anticipates that the eligibility process make

take some time. The facility's Medicaid worker acknowledged it “takes months” [(“30 days to 9 months” C.470)] to process a Medicaid application, that all that is required during the application process is that the resident “pay their financial part,” i.e. the “resident care credit,” and that so long as they do there is no involuntary discharge action filed against them. (C.470-471).

3. Other Errors of the Department.

Besides the above, the Administrative Law Judge (ALJ) made several significant errors and misstatements in her FINDINGS OF FACT/CONCLUSIONS OF LAW. She stated “Ms. Slepicka was approved for Medicaid dating back to the admission date of March 29, 2011.” The date is incorrect. Ms. Slepicka's Medicaid was approved by DHS to start June 1, 2011. The initial decision dated February 17, 2012 (C.651) approved the application “beginning 06/11” - likewise the final decision, dated July 6, 2012, recognized her approval “beginning 06/11.” (C.24).

The ALJ also stated: “...there were no Medicaid beds available.” There were in Medicaid beds available. The Administrative Law Judge's finding, upon which the decision is based, is unfounded and contrary to the unrefuted facts - Roberta Magurany, administrator of the facility testified, *inter alia*, that:

***14** i. She made no inquiry whether any Medicaid bed was available between June 1, 2011 and March 3, 2012; but,

ii. There were **private pay occupants in certified beds** during that entire period of time. (Emphasis added.)

The exact testimony elicited from the Administrator regarding occupancy of beds appears at page 117 of the Transcript, (C.485), and goes:

Q Did you make any inquiry before the hearing today to determine whether or not a Medicaid bed was available at any time after June 1st, 2011, before March 3rd -- March 4th, 2012, into which Mary Slepica could have been moved?

A No.

Q You can't tell us today whether there was any such?

A No.

Q All right. And the - so you can't tell us whether there were any private pay occupants of any Medicaid-certified bed during any date from June 1 to March 4th, 2012 either, can you?

A There were private pay in the certified beds, yes.

Q During that period of time?

A Um-hum. [3]

The facility fiscal officer also acknowledged that Medicaid beds are used for Medicare and private residents as well as Medicaid. Prior to admitting the facility populated at least some Medicaid certified beds with private pay residents, the Administrator acknowledged that the facility's contract assures residents that the facility itself is “going to do everything it can do to get people on - - get medical assistance.” (C.481). The family is expected to co-operate. (C.481).

***15** The Administrator's own hand-written comments on the November 1, 2011 billing statement (included in the Appendix at A.12) makes it clear that the facility knew Ms. Slepicka should be transferred to a Medicaid certified bed. There were private pay residents in Medicaid beds - why did the facility not just make the transfer, which it could under its own contract? How can

the facility be allowed to penalize the Plaintiff for its own indolence? The facility knew she was seeking Medical Assistance - it could have reassigned her to a certified bed and moved a private pay resident out of the certified bed in exchange. It chose not to.

According to Ms. Slepicka's April 10, 2011 contract with HFV, the facility reserved control over room assignments:

> Room Assignments and Roommates. **HOLY FAMILY shall assign rooms and roommates as needed.** Resident has the right to reside and receive services in HOLY FAMILY with reasonable accommodation of individual needs and preferences, except when, as determined by HOLY FAMILY, the health or safety of Resident or of other residents would be endangered. Resident, Resident's legal representative, if any, or interested family member has the right to receive notice before Resident's room or roommate is changed. Resident has the right to share a room with his or her spouse when married residents live in the same HOLY FAMILY and both spouses consent to the arrangement. Resident has a right to refuse a change of rooms within HOLY FAMILY if the purpose of the change is merely for the purpose of obtaining Medicaid funding. [¶24] [Emphasis added]

The conclusion that the facility wanted to keep Ms. Slepicka in a private pay bed is compelling. The motive of financial gain seems clear. The private pay rate for HFV according to Ms. Slepicka's billing ***16** statements was $232/day ($6,960 for a 30-day month, $7,192 for a 31-day month). When a nursing home contracts with the State of Illinois to accept Medicaid benefits, the room rate is significantly less than the private pay rate, in this case $137.16 per day instead of $232 per day. (C.695). Since HFV controls room assignments and since the HFV administrator testified there were private pay residents in certified Medicaid beds, we can only conclude that the nursing home intentionally kept her in a private pay bed to exploit her financially.

The decision of the Administrative Law Judge also states, “Medicaid will not pay for Ms. Slepicka's non-certified bed from April 10, 2011 to March 3, 2012.” (C.10). There is no support in the record for that conclusion. The facility's witnesses testified no billing was made to Medicaid “because she was not in a certified bed.” (C.399). She was “considered” a private pay resident. (C.412). It is true Medicaid will not pay for April 10 thru May 30, 2011 because those dates were before her Medicaid award was effective and are not disputed. However, DHS approved her Medicaid application effective June 1, 2011 and the DHS notices show exactly how much Ms. Slepicka owes the nursing home each month from June 1, 2011 forward. The initial DHS decision and all subsequent corrected notices were provided to the Administrative Law Judge and HFV, including the final decision dated July 6, 2012 supplied to the ALJ per her request as we noted above. (See especially C.22-47).

***17** It is the Department of Human Services, not the Department of Public Health and not Holy Family Villa, who determines what Medicaid will pay and what Ms. Slepicka's monthly resident liability is for each month of Medicaid eligibility. 305 ILCS 5/5-4. According to the DHS's final and correct decision dated July 6, 2012, for the months of June thru September 2011, Ms. Slepicka owes $0.00 for June, she owes $0.00 for July, $1,080.49 for August 2011, and $1,811.30 for September 2011. The initial Medicaid decision on February 17, 2012 had already correctly calculated the monthly resident liability of $3,965.99 for the months of October thru December 2011. The amounts then increased to $4,026.09 for January and February 2012. The total amount DHS says is Ms. Slepicka's resident liability to HFV for these nine months is $22,841.94. The total amount Ms. Slepicka paid HFV for those nine months was **$51,088.35.** Ms. Slepicka has overpaid HFV **$28,246.41** according to what DHS says she owes HFV. (C.678). According to Ms. Slepicka's contract at paragraph 8(b) with HFV, they owe her a refund of the **$28,246.41** overpayment.

4. Resident Contract with Holy Family Villa.

The Resident's contract for skilled care with the facility dated April 10, 2011 expressly provides that the bill claiming an unpaid balance is invalid:

> Since HOLY FAMILY will accept public financial assistance in lieu of sources of private payment, **Resident and Other Parties agree to take all steps necessary to apply for and *18 to obtain public financial assistance** under any program for which Resident may be eligible. [116(c)] (Emphasis added.)

And further:

> In the case of an approved Medicaid recipient, **HOLY FAMILY shall not charge, solicit, accept or receive, in addition to any amount otherwise required to be paid under the state and federal Medicaid programs, any** gift, **money,** donation, or **other consideration** as a precondition of admitting (or expediting the admission of) the individual to HOLY FAMILY or as a requirement for Resident's continued stay in HOLY FAMILY. [¶8(b)] (Emphasis added.)

And yet further:

> Residents covered under the Medicaid Program administered by IDPA must contribute a portion of their income towards the cost of care, and Medicaid will pay the balance. The portion the Resident must pay is called Resident Liability. **This amount will be determined at the time of Medicaid approval by the IDPA caseworker.** It is necessary that HOLY FAMILY receive the Resident Liability by the 5th of each month. All payments of Resident Liability should be made payable to HOLY FAMILY VILLA and sent or delivered to the Business Office of HOLY FAMILY. Do not make payment to other HOLY FAMILY personnel. Failure to pay the above Resident Liability may result in involuntary discharge of Resident with proper discharge planning. [¶8(k)] (Emphasis added.)

On February 17, 2012, DHS (f/k/a DPA - Illinois Department of Public Aid) initially approved Ms. Slepicka for Medicaid benefits and determined her monthly resident liability. (C.651). The initial decision by DHS on February 17, 2012 calculated the monthly resident liability for October 2011 and forward (through 2011) correctly, but was in error for the months of June-September 2011. Those errors were corrected ***19** through revised decisions on March 1, March 20, April 2, and July 6, 2012. (C.522; C.525; C.136). The July 6, 2012 decision from DHS is the final and correct decision for June thru September 2011. (C.136).

Based on the correct DHS decisions approving Ms. Slepicka for Medicaid, she overpaid HFV $20,534.81 for June - December 2011, and she overpaid HFV $7711.60 for January - February 2012. The total amount Ms. Slepicka has overpaid HFV for June 2011 through February 2012 is $28,246.41. She has also made her monthly resident liability payments to HFV for each month since March 2012. According to the contract paragraph 8(b) Ms. Slepicka is owed a refund of $28,246.41 from HFV. Based not only on federal law, but the plain terms of the facility's contract, the facility cannot even accept, let alone demand, any money or additional consideration beyond the Medicaid approval. (See 305 ILCS 5/5-4; and Para. 8(b) of the contract.)

5. The Facility's Financial Motive.

It is easy to understand the financial incentive for the facility to keep Ms. Slepicka in a private pay bed. When she came into the facility she owned a home which constituted the bulk of her assets. (C.239; C.640). Her other assets were acknowledged to be modest. (C.460) She sold her home. (C.83). The facility expected her to spend all her non-exempt assets for private pay care “for three to four years.” (C.435-6).

On advice of her attorney Ms. Slepicka employed a Certified Financial Consultant to handle her Medicaid application. (C.514-519). ***20** Part of the planning recommended by her financial advisor was to purchase a single premium immediate retirement annuity under the Medicaid rules. This is a perfectly acceptable planning tool. Lopes v. Starkowski (2012) (10-3741-

CV), 696 F.3d. 180, 2012 WL 4495500, a copy of which was filed in the record. (C.309). This device allows the Medicaid applicant to convert assets to a stream of income over her life expectancy, and, accelerates her Medicaid eligibility. If she outlives the annuity, the facility ends up with all payments of the annuity until the annuity is exhausted; if she outlives the period calculated by the facility to exhaust the non-exempt assets, and can leave the facility, she has some additional income to live on until the annuity is exhausted.

The $62,594.40 "prize" the facility has its eyes on was calculated in this record. (C.695-696). The daily rate increase to the facility was $94.84. (C.696). The additional costs to the State over her life expectancy is also dramatic. (C.694).

6. A Growing National Issue.

This case involves a growing national issue. Nursing homes are wrongly involuntary discharging residents for financial gain. Here are a few excerpts from a recent ***Elder*** *Law Journal* article:

I. Introduction

Nursing homes serve an essential function in the long-term care continuum by providing nursing care around the clock to **elderly** residents. By entrusting nursing homes with its most **vulnerable** members, society relies on these institutions and the regulations that govern them to ensure that the **elderly** are treated ***21** with a reasonably adequate level of care. This trust, however, has been misplaced.

Hospital dumping, improper eviction, and wrongful discharge are all variations of the same practice: the unlawful involuntary discharge of a nursing home resident. In recent years, the number of formal complaints and news stories detailing improper nursing home discharge practices has grown. Nursing homes across the country shirk their duties and fail to follow proper protocol in discharging residents. This leaves **elderly** residents and their families with the difficult task of finding suitable alternative care.

III. Analysis

A. Why Nursing Homes Unlawfully Discharge Residents

1. UNDERFUNDING FROM MEDICAID-SPONSORED RESIDENTS

Residents paying for nursing home care via Medicaid are prime targets for unlawful discharge. Nursing homes, like any other business, must make money to remain financially viable. This money comes from payment by residents for their long-term care at the nursing home facility. Medicaid-sponsored residents, however, end up paying nursing homes much less than similarly situated residents paying via Medicare or private funds. **Due to this discrepancy, residents paying via Medicaid make an attractive target for nursing homes to unlawfully discharge. Attempting to involuntary discharge a resident because of his or her method of payment, however, is illegal under federal regulations. Yet, nursing homes continue to do so because of the dramatic difference in compensation between what Medicaid-sponsored residents and private pay residents pay nursing homes for providing long-term care. (Emphasis added.)**

***22** B. How Nursing Homes Avoid Liability When Unlawfully Discharging a Resident

1. NURSING HOME RESIDENTS ARE NOT AWARE OF THEIR RIGHTS

Although the laws regulating nursing homes provide a variety of safeguards for nursing home residents, many residents and their families are unaware of the rights they possess and, therefore, do not exercise them. The **Elder** Law Journal, Volume 20, No.1 (2012), 235, *"You Don't Have to Go Home But You Can't Stay Here: The Current State of Federal Nursing Home Involuntary Discharge Laws"*

SUMMARY

To summarize:
1. Ms. Slepicka was approved for Medicaid benefits beginning June 1, 2011 forward;

2. Holy Family Villa had Medicaid certified beds available, albeit some were occupied by “private pay” residents;

3. The facility controlled room assignments; any prejudice flowing from an incorrect bed assignment must be laid at the feet of the facility;

4. Federal Law [42 CFR 483.12(a)(2)(v)] expressly prohibits charging Ms. Slepicka beyond what Medicaid approved or allowed for her;

5. The contract with the facility likewise recognizes the facility's obligation to accept only sums approved by Medicaid;

***23** 6. Ms. Slepicka has overpaid the facility $28,246.41 and according to the April 10, 2011 contract it owes Ms. Slepicka a refund for same amount; and,

7. The decision of the Department must be reversed for reasons that the facility's bill claiming an outstanding balance was invalid - there was no “failure to pay.”

VIII. CONCLUSION

Plaintiff-Appellant prays the court reverse the trial court, enter judgment for the plaintiff on all issues and remand for an adjustment of Plaintiff's account in accord with the Medicaid determination, and an award of fees in favor of the Plaintiff-Appellant and against the Defendant-Appellee.

Footnotes

1 A brief review of the provisions of 210 ILCS 45/3-401, et seq. seems to suggest that the rights of a resident under Illinois law might be governed by federal law in any event.

2 At the hearing the ALJ expressly kept the record open to receive the final and corrected decision of the DHS/DHFS decision on Medicaid eligibility which was done on July 6, 2012 (See C.381); the trial court expressly allowed the record to be supplemented with that decision. (C.732; d/e 11/28/2012). It appears at C.24 and C.136.

3 “Um-hum” means “yes,” (C.465; C.480)

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